Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/16/03.

I. DISPUTE

Whether there should be reimbursement for HCPCS codes E1399, A4556 (x2), A4557, and E0731, for dates of service 9/11/03 – 10/10/03.

II. RATIONALE

The service in dispute was denied as, "A/N-Total DME for 9/11/03 date of service is in excess of $500.00; Not Preauthorized."

Requestor states that, "Preauthorization not required, line item does not exceed $500.00."

Carriers statement of position dated 1/28/04 states, "The reason for denial was listed as: A/N = NMS units are indicated for acute stage of injury. The date of service is ___ months post injury. Accumulative charges for 9/11/03 are in excess of $500.00. Preauthorization was not obtained."

Commission Rule 134.600 (h) (11) states that, "The non-emergency health care requiring preauthorization includes: All durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental) and all transcutaneous electrical nerve stimulators (TENS) units."

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	HCPCS CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
9/11/03 – 10/10/03	E1399	$250.00	$0.00	A/N	No MAR	Rule 134.600 (h)(11) and Rule 133.307 (j)(F)	The Carrier did not raise the issue of fair and reasonable. No MAR, paid at fair and reasonable. Reimbursement recommended in the amount of $250.00.
9/11/03 – 10/10/03	A4556 (x2)	$80.00 per unit	$0.00	A/N	$12.14 (per unit) x 125% x 2	Medical Fee Guideline, Medicare Fee Schedule, and Rule 134.600 (h)(11)	No preauthorization required. Reimbursement recommended in the amount of $30.36.
9/11/03 – 10/10/03	A4557	$40.00	$0.00	A/N	$21.10 x 125%	Medical Fee Guideline, Medicare Fee Schedule, and Rule 134.600 (h)(11)	No preauthorization required. Reimbursement recommended in the amount of $26.38.
9/11/03	E0731 NU	$350.00	$0.00	A/N	$303.19 x 125%	Medical Fee Guideline, Medicare Fee Schedule, and Rule 134.600 (h)(11)	No preauthorization required. MAR amount is greater than providers' fair and reasonable. Reimbursement is recommended in the amount of $350.00.
Total							Total reimbursement recommended, $656.74

III. DECISION AND ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement in the amount of $ 656.74. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $656.74 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 30th day of April 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc